



MASSACHUSETTS
HEALTH POLICY COMMISSION

Annual Health Care
Cost Trends Hearing

CTH 2016

Executive Summary

MASSACHUSETTS HEALTH POLICY COMMISSION

Annual Cost Trends Hearing

October 17-18, 2016

Suffolk University Law School, Boston, Massachusetts

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INTRODUCTION

On October 17 and 18, 2016, the Massachusetts Health Policy Commission (HPC) convened its fourth annual health care cost trends hearing at Suffolk University Law School in Boston, Massachusetts. The annual hearing is a public examination into the drivers of health care costs in Massachusetts and an opportunity for policymakers, researchers and witnesses who participate in the Commonwealth's health care system to identify particular challenges and opportunities for improving Massachusetts health care cost trends.

The two-day 2016 hearing featured keynote remarks from the Governor and Attorney General, presentations by policymakers and two national experts, and in-person witness testimony from top health care executives, industry leaders, and consumer and business representatives. The public hearing format allowed the HPC's commissioners to question these key stakeholders about the state's performance under the state's Health Care Cost Growth Benchmark and other health care reform efforts.

The 2016 hearing featured four witness panels and two reactor panels. These panels provided the audience with thoughts, concerns, and suggestions for upcoming research and policy initiatives. Panels addressed the following topics:

- Meeting the Health Care Cost Growth Benchmark
- Employer Perspectives
- The Evolving Provider Market
- Strategies to Address Social and Behavioral Health Needs
- Strategies to Address Pharmaceutical Spending Growth
- Consumer Perspectives

This Executive Summary is intended to summarize the major themes raised by hearing participants. The assertions, conclusions, and recommendations described do not necessarily reflect the position of the HPC or its commissioners. Watch full recordings of the hearing at mass.gov/HPC.

VISIBILITY AND REACH

Nearly 400 people attended the 2016 hearing, with an additional 2,700 individuals watching via the online live stream from across the nation. The 2016

hearing was the first to draw an international audience, with viewers from Germany, the Philippines, the United Kingdom, and Australia.

AUDIENCE



- Nearly **400** individuals in-person
- Over **2,700** individuals watching online
- Viewers came from the **US, Germany, the Philippines, the UK, and Australia**

WEBSITE



- **5,330** unique website visits
- **6.6%** of all traffic to the Mass.Gov website
- The majority of people navigated to the **Cost Trends Hearing** agenda and materials

TWITTER



- **143** Official HPC Tweets
- **69,800** impressions (potential views by unique Twitter users)
- **32%** outside of Massachusetts with **4%** outside of the US
- **304** Retweets → **175** Likes → **50** Replies

MEDIA



- **25** unique articles across **14** major news outlets

AGENDA: MONDAY, OCTOBER 17

Opening Remarks	9:00AM
Dr. Stuart Altman, Chair, Health Policy Commission Ms. Renee Landers, Director of the Health Law Concentration, Suffolk University Law School The Honorable Jeffrey Sánchez, House Chair, Joint Committee on Health Care Financing	
Keynote Remarks	9:30AM
The Honorable Charlie Baker, Governor	
Presentation	9:50AM
Mr. Ray Campbell, Executive Director, Center for Health Information and Analysis Dr. David Auerbach, Director, Research and Cost Trends, Health Policy Commission	
National Perspectives	10:15AM
Dr. Robert Berenson, Institute Fellow, The Urban Institute	
Witness Panel: Meeting the Health Care Cost Growth Benchmark	11:00AM
Dr. Steven Strongwater, President and CEO, Atrius Health Dr. Mark Keroack, President and CEO, Baystate Health Mr. Andrew Dreyfus, President and CEO, Blue Cross Blue Shield of Massachusetts Ms. Christina Severin, President and CEO, Community Care Cooperative Mr. Eric Schultz, President and CEO, Harvard Pilgrim Health Care	
Reactor Panel: Employer Perspective	12:30PM
Ms. Laurel Pickering, President and CEO, Northeast Business Group on Health Ms. Patricia Begrowicz, Owner, Onyx Paper	
Lunch Break	1:15PM
Presentation	2:00PM
Office of the Attorney General	
Witness Panel: The Evolving Provider Market	2:15PM
Ms. Gail Sillman, CEO, Central Massachusetts Independent Physicians Association Dr. Howard Grant, President and CEO, Lahey Health Dr. Joseph Frolkis, President and CEO, NEQCA Dr. Gene Green, President and CEO, South Shore Health System Mr. Thomas Croswell, President and CEO, Tufts Health Plan	
Public Testimony	3:30PM

PowerPoint presentations hyperlinked above.

AGENDA: TUESDAY, OCTOBER 18

Opening Remarks Dr. Stuart Altman, Chair, Health Policy Commission The Honorable Stanley Rosenberg, Senate President	9:00AM
Keynote Remarks The Honorable Maura Healey, Attorney General	9:30AM
Presentation Office of the Attorney General	9:50AM
National Perspectives Ms. Lauren Taylor, Harvard Business School, Health Policy and Management	10:20AM
Witness Panel: Strategies to Address Social and Behavioral Health Needs Ms. Kate Walsh, President and CEO, Boston Medical Center/ BMC HealthNet Dr. Toyin Ajayi, Chief Medical Officer, Commonwealth Care Alliance Dr. Manny Lopes, CEO, East Boston Neighborhood Health Center Mr. Spiros Hatiras, President and CEO, Holyoke Medical Center Dr. Elsie Taveras, Chief, Division of Pediatrics, Massachusetts General Hospital	11:00AM
Reactor Panel: Consumer Perspective Ms. Alice Dembner, Director, SUD Project, Community Catalyst Mr. Brian Rosman, Policy and Government Relations Director, Health Care For All Ms. Alexis Snyder, Patient Family Advisor	12:30PM
Lunch Break	1:15PM
Witness Panel: Strategies to Address Pharmaceutical Spending Growth Dr. Deborah Schrag, Surgical Oncology Chief, Dana-Farber Cancer Institute Dr. Rick Weisblatt, Chief of Innovation and Strategy, Harvard Pilgrim Health Care Dr. Gregg Meyer, Chief Clinical Officer, Partners HealthCare System Ms. Lisa Joldersma, VP, Policy and Research Development, PhRMA	2:00PM
Public Testimony	3:30PM

PowerPoint presentations hyperlinked above.

MAIN TAKEAWAYS

Over the two-day event, 24 health care executives, industry leaders, and employer and consumer representatives testified on six witness panels. The themes listed below are based on assessments and recommendations made by panelists during the event.

IDENTIFICATION OF CHALLENGES

1. Pharmaceutical price increases and a lack of pricing transparency are primary concerns for payers and providers.
2. Growing health insurance premiums are a significant burden for businesses and consumers.
3. Acquisitions of physicians, including acquisitions under established thresholds for public reporting, are driving consolidation of care into large, hospital-based systems. Providers believe that consolidation creates efficiencies but they lack data demonstrating resulting cost savings.
4. Massachusetts continues to have significantly higher rates of hospital readmissions and emergency department utilization than the rest of the country.
5. Provider price variation continues to be a major concern.

FORWARD-LOOKING STRATEGIES

1. Aligned quality measurement and reporting are critical to enhancing the effectiveness of alternative payment methods and reducing administrative burden.
2. Properly addressing social determinants of health requires investment but has the potential to produce long-term cost savings and increase overall wellness.
3. Community-based care has the potential to improve outcomes and reduce costs, as local resources often best identify gaps in care.
4. Patient involvement and engagement are key to cost containment and transformation efforts.
5. Improving price transparency, especially for physicians at the time of referral, can promote high-value care.
6. Telemedicine has the potential to enable cost-effective care and is growing in use, but reimbursement policies and other barriers keep it from being used widely.

OVERVIEW OF PANELS

MEETING THE HEALTH CARE COST GROWTH BENCHMARK

While per-capita health care spending growth in Massachusetts has been generally in line with the 3.6% benchmark for the past two years, overall affordability of health care continues to be a challenge for many low and middle income residents in Massachusetts. The purpose of this panel was to discuss health care cost growth in the Commonwealth, including a discussion of findings from CHIA's Annual Report on the Performance of the M Health Care System, as well as efforts to advance and align alternative payment methodologies.

WITNESSES

- I. Atrius Health
- II. Baystate Health
- III. Blue Cross Blue Shield of Massachusetts
- IV. Community Care Cooperative
- V. Harvard Pilgrim Health Care

FOCUS AREAS

- Meeting the goals of Chapter 224
- Adoption of alternative payment methods
- Impact of pharmaceutical and medical device pricing trends
- Out-of-network billing

MAIN TAKEAWAYS FROM THE PANEL:

- **Pharmaceutical price increases and a lack of pricing transparency are primary concerns for payers and providers**
Panelists believe the state should consider implementing policies that promote transparency, accountability, and value-based pricing of pharmaceuticals.
- **Health plans are using demand-side incentives to attract consumers to high-value products and providers**
Health plans are trying to create tiered and limited network plans that will appeal to consumers. Panelists mentioned that employer preference for PPOs over HMOs may stall efforts to increase alternative payment models (APM) adoption, and that the HPC should consider encouraging use of the consensus guidelines for non-HMO attribution to expand APMs to non-HMO patients.
- **Improving price transparency, especially for physicians at the time of referral, can promote high-value care**
Health plans also expressed interest in increasing price transparency and expanding consumer incentives beyond differential copays in order to guide consumers toward high-value care.
- **Panelists expressed urgency in moving away from fee-for-service payment models and to align incentives**
Panelists felt that global budgets and other APMs would need to be fully separated from fee-for-service models in order for system-wide change to occur. Health plans suggested that bundled payment models work well as complements to, rather than substitutes for, global budgets and expressed concern that fee-for-service models could become “fee-for-bundles” without careful planning.
- **Health plans are cautiously receptive to future participation in claims data submission to the state’s all-payer claims database**
Health plans had varied responses when it came to whether we can count on them to participate in the all-payer database (APCD) for their self-insured plans in the absence of a federal requirement to do so. Harvard Pilgrim Health Care vocalized support for an all-payer database that includes both claims and clinical data, and identified this as a potential opportunity for a public/private partnership. Blue Cross Blue Shield of Massachusetts expressed a desire for federal clarification on APCD regulations. Both plans voiced support for data transparency regarding cost and quality.
- **Telemedicine has the potential to enable cost-effective care and is growing in use, but reimbursement policies and other barriers keep it from being used widely**
Health plans and providers are interested in using telemedicine to address behavioral health. They hope that new incentives for providing and using telemedicine can help reduce emergency department visits and hospital admissions.

REACTOR PANEL: EMPLOYER PERSPECTIVE

Employers play a key role in the Commonwealth's health care system. The purpose of this panel was to review health insurance premium trends from the employer point of view and discuss value-based health care strategies businesses are using, such as plan design and employee engagement.

WITNESSES

- I. Northeast Business Group on Health
- II. Onyx Specialty Paper

FOCUS AREAS

- Role of employers in promoting value-based health care
- Plan and benefit design strategies
- Employee engagement
- Health insurance premium trends

MAIN TAKEAWAYS FROM THE PANEL:

- **Growing health insurance premiums are a significant burden for businesses and consumers**
As costs rise, higher percentages of total compensation for employees go to health insurance. With higher per-employee burden, companies face bottom line and hiring challenges; employees see reduced take-home pay and sacrifice cost-of-living wage increases.
- **The HPC should consider helping businesses develop and share cost containment strategies**
Panelists noted that, unlike many other states, Massachusetts does not have a Business Group for Health. Panelists believe that the HPC should consider using its convening authority to help businesses collaborate, as well as track efforts of individual businesses. Successful strategies discussed include larger employers directly contracting with providers for company-wide care, as well as involving employees in managing their own care.
- **Smaller employers are experimenting but still struggle with cost containment**
Unlike larger employers, who have the benefits of economies of scale and larger administrative capacity, small businesses have few resources to address rising costs on their own, and similarly cannot afford to participate in industry-advocacy organizations. Because they compete with large companies for talent, small businesses feel pressure to offer benefit-rich health plans to employees. Panelists believe the HPC can use its research capabilities to evaluate how small businesses can successfully implement cost containment strategies.

PROVIDER MARKET

The provider market in Massachusetts has continued to transform over the past year, seeing new consolidation and some shifting in focus from inpatient to outpatient care. In their 2016 pre-filed testimony, surveyed providers listed prescription drug costs, commercial payment rates for behavioral health, provider price variation, and labor costs as their top areas of concern.

WITNESSES

- I. Central Massachusetts IPA
- II. Lahey Health
- III. NEQCA
- IV. South Shore Health System
- V. Tufts Health Plan

FOCUS AREAS

- Continued provider consolidation
- Shift in care from inpatient to outpatient settings
- Physician recruitment and employment trends
- Future role for community hospitals and independent physician practices
- Provider price variation

MAIN TAKEAWAYS FROM THE PANEL

- **Aligned quality measurement and reporting are critical to enhance the effectiveness of APMs and reduce administrative burden**
Provider and payer panelists agreed that alignment of quality measurement and reporting across payers, providers, and state agencies would relieve administrative and financial burdens while also leading to better assessments of value. Panelists expressed a willingness to work with the HPC on this subject, and specifically suggested a payer-blind set of metrics. Some commissioners also urged including patient-reported outcomes. Panelists also noted that physicians should be included in the development of any uniform system.
- **Provider price variation continues to be a major concern**
Some providers stated that price variation, coupled with increasing costs and decreasing government reimbursement, is a significant threat to smaller providers. If provider price variation is not addressed, these smaller providers may be forced to close, sending patients to larger, higher-priced providers and increasing overall health care spending.
- **Physicians are key to cost containment efforts, but face high administrative burdens**
Providers noted that significant administrative burdens on physicians have made integration more attractive and that discussions of quality measurements must be focused on existing physician workflows to minimize burden. Panelists noted that transparency efforts should include physician access to cost information to inform patients and referrals. Panelists noted that the administrative burden and constraints of regulation discourage innovative, and potentially cost-saving, practices.
- **Acquisitions of physicians, including acquisitions under the HPC's notice of material change thresholds, are driving consolidation of care into large, hospital-based systems. Providers believe that consolidation creates efficiencies but they lack data demonstrating resulting cost savings**
Some panelists advocated for investments into primary care services and system integration as a means of efficiency. Others noted that recruitment and employment of physicians by high-cost systems continues to drive up prices and frustrate recruiting efforts by low-cost systems. Panelists argued that some of their past transactions have produced efficiencies such as shifting referrals to more efficient sites of care, and avoiding unnecessary admissions/readmissions. However, when pressed, panelists stated that they were not yet able to show that any efficiencies have translated into measurably lower spending.

PANEL OVERVIEW

STRATEGIES TO ADDRESS SOCIAL AND BEHAVIORAL HEALTH NEEDS

Addressing social and behavioral health needs has emerged as a key cost containment strategy. The purpose of this panel was to discuss providers' adoption of alternative payment models that support innovative care models, as well as partnerships between health care organizations and community agencies.

WITNESSES

- I. Boston Medical Center
- II. Commonwealth Care Alliance
- III. East Boston Community Health Center
- IV. Holyoke Medical Center
- V. Massachusetts General Hospital

FOCUS AREAS

- Efforts to address social determinants of health
- Efforts to integrate behavioral health
- Alternative payment methods to support innovative care models
- Models of partnership between health care organizations and community agencies

MAIN TAKEAWAYS FROM THE PANEL

- **Patients' social and behavioral health needs present unique challenges for providers**

Panelists noted difficulties in determining when a patient's economic or social problem comes into their purview. The typical fee-for-service payment model does not incentivize providers to go beyond addressing patients' clinical issues because they cannot bill for addressing things like transportation, child care, or other non-medical services. Traditional providers, such as hospitals, typically operate under a model that produces inefficiencies when applied to social determinants of health (SDH) and behavioral health (BH) issues. Further, providers expressed uncertainty about where their accountability should start and end – questioning whether providers should be accountable for addressing patients' social or economic issues.

- **Properly addressing social determinants of health requires investment but has the potential to produce long-term cost savings and increase overall wellness**

Panelists concur that addressing SDH and integrating BH will reduce overall health care costs. But, because the return on investment for this type of care is typically long term, institutions should re-focus their strategies towards long-run savings through short-run expenditures. Namely, addressing SDH and integrating BH for children today will produce savings in the long-run.

- **Budgetary constraints are a central barrier to providers addressing social determinants of health and integrating behavioral health**

Panelists believe that risk adjustment methodologies for capitation do not adequately support social determinants of health and behavioral health integration. Panelists noted that capitated budgets, which are typically built up from existing services, leave providers with difficult resource allocation challenges. Other challenges include low reimbursement (especially for BH) and an unsustainable reliance on philanthropy.

- **Community-based providers are well-suited to identify and address gaps of care**

Health centers or community-based providers often have a better understanding of the social, behavioral and other medical care resources in their community. The representative from the East Boston Neighborhood Health Center described a collaborative program with Bunker Hill Community College which trains a community-based workforce that is equipped to identify and address locally-relevant social determinants of health. All participants noted the need for better “asset maps” or community-specific resources to help provider address patients' social and behavioral health needs.

REACTOR PANEL: CONSUMER PERSPECTIVE

The purpose of this panel was to discuss the role of consumers in promoting value-based health care, the importance of social determinants of health, efforts to engage patients and families in health care system transformation, and the impact of rising pharmacy costs on consumers and patient access.

WITNESSES

- I. Community Catalyst
- II. Health Care For All
- III. Patient Family Advisor

FOCUS AREAS

- Role of consumers in promoting value-based health care
- Importance of social determinants of health
- Efforts to engage patients and families in health care system transformation
- Impact of pharmacy costs on consumers and patient access

MAIN TAKEAWAYS FROM THE PANEL

- **Patient involvement and engagement are key to cost containment and transformation efforts**
Payment reform efforts should incentivize patient activation, shared decision making, and measurement of patient confidence. Patient Family Advisory Councils (PFACs) are a proven tool for provider organizations.
- **Community-based care has the potential to improve outcomes and reduce costs, as local resources often best identify gaps in care**
Providers and health systems should focus on partnering with in-community resources rather than attempting to develop “culturally competent” care on their own.
- **Eliminating cost-sharing via public policy can have unintended consequences**
Panelists noted that eliminating or reducing cost-sharing for preventive services, such as asthma inhalers, would incentivize prevention, reducing long-term costs for that patient. However, panelists also discussed unintended consequences of policies such as free wellness visits, where there is no co-pay to the patient unless the patient mentions anything outside the scope of the wellness exam during that visit, at which point, charges can accrue.
- **The Commonwealth should consider establishing policies to address high pharmaceutical drug prices**
Panelists suggested:
 - (a) Developing price transparency reporting and price justification requirements
 - (b) Prohibiting drug coupons and rebate arrangements, which increase consumer prices
 - (c) Prohibiting “drug dinners,” in which pharmaceutical companies can buy meals for doctors, possibly providing perverse incentives to prescribe
 - (d) Implementing an academic detailing system, in which unbiased clinical consultants offer clinical information about drug therapy and best practices assisting with prescription decision.
- **Diversion programs in the criminal justice system should integrate health supports**
Panelists suggested that criminal justice and community health systems should partner to identify populations at risk of substance abuse and mental illness, and offer them appropriate preventive care to avoid both incarceration and/or hospitalization.

STRATEGIES TO ADDRESS PHARMACEUTICAL SPENDING GROWTH

The growth rate for prescription drug spending has continued to significantly outpace overall health care spending growth. The purpose of this panel was to provide an in-depth examination of the impact on increasing pharmaceutical spending.

WITNESSES

- I. Dana-Farber Cancer Institute
- II. Harvard Pilgrim Health Care
- III. Partners HealthCare System
- IV. PhRMA

FOCUS AREAS

- Impact of rising pharmaceutical costs on payers, providers, and patients
- Innovative strategies to mitigate pharmaceutical spending trends
- Transparency of pharmaceutical prices and spending trends net of rebates/discounts

MAIN TAKEAWAYS FROM THE PANEL

- **Rising drug costs are producing a multi-dimensional negative impact across the market**
At the end of 2015, 25% of Harvard Pilgrim Health Care's (HPHC) total medical costs were drug costs (medical and pharmacy), and that figure was rising in double digits. Across all commercial contracts at Partners HealthCare, the trend rate in drug cost growth in 2015 was 3.4%, of which 2.2% was pharmaceutical, including 1.6% for specialty drugs. In Partners' self-insured employee population, the trend rate was 2.4%, of which 2.3% was pharmaceutical drug costs (versus 0.1% for medical drugs). With respect to price increases, commissioners cautioned that if prior price increases, which are embedded in growth statistics, were not themselves justified, the current price increases are not justifiable.
- **In addition to specialty drugs, generic drug pricing is a key driver of pharmaceutical spending increases**
Panelists noted that some drugs, which have been on the market for decades, have increased in price thousands of percent over the past few years. Providers feel they are reaching a saturation point with respect to generic drugs as percentage of total prescriptions written, and cannot expect to see significant new savings by switching from branded to generics.
- **Panelists are engaging in some innovative strategies to reduce spending on high-cost drugs**
Panelists spoke about certain innovative strategies to mitigate pharmaceutical spending trends, such as:
 - (a) HPHC's outcome-based contracting with one manufacturer (e.g., performance targets around lowering LDL with cholesterol drugs and performance penalties for use outside of the target population)
 - (b) Partners' aggressive formulary management (e.g., saying "no" to intravenous acetaminophen, which can cost 15-50x more than oral), provider prescribing practices, and future pricing strategies (i.e., payment for value, not volume);
 - (c) Dana-Farber Cancer Institute's call to invest in the evidence base and improve learning about outcomes and consequences from every patient.
- **The HPC can take a leadership role in drug price transparency and cost containment efforts**
Surveyed providers do not have access to adequate information about the cost of drugs at the point of prescribing. While some information is available to patients (regarding out-of-pocket expenses, for example), providers do not have access to comprehensive, timely information, and the information to which they do currently have access is not sophisticated. Payer and provider panelists agreed that more effort

(Continued)

STRATEGIES TO ADDRESS PHARMACEUTICAL SPENDING GROWTH

is needed in this space, they expressed a willingness to coordinate, and they suggested that the state take a leadership role in data collection.

Other initiatives that panelists and commissioners discussed included:

- (a) HPC tracking of medical trend and pharmacy trend separately
- (b) Monitoring efforts such as California's drug purchasing ballot initiative
- (c) Group purchasing
- (d) Encouraging providers to directly negotiate prices (i.e., no discounts, rebates, coupons)
- (e) Monitoring/supporting partial-prescription-fill regulations at the federal and state level

PRE-FILED TESTIMONY

PRE-FILED TESTIMONY

The HPC is required by its governing statute to identify a number of health care providers and payers as witnesses for the annual cost trends hearing. The HPC requested written pre-filed testimony from staff-identified providers and payers in addition to calling 24 individuals/organizations to testify in-person at the two-day hearing. The pre-filed and in-person testimony helps to inform research projects and policymaking across state government, including the HPC's annual cost trends report.

Pre-filed testimony consists of responses to approximately ten questions on a variety of topics, such as alternative payment methodologies, behavioral health integration, and price transparency.

In July 2016, the HPC sent requests for pre-filed testimony to 46 payers, providers, and hospitals across the Commonwealth. Written testimony was due back to the HPC in September 2016. All testimony can be found at mass.gov/HPC.



62% of all respondents identified pharmaceutical spending as the a **top concern** for meeting the Benchmark

100% of providers and hospitals responded that their EHR system **does not provide cost and quality data** at the point of referral making it **difficult** to promote high-value referrals



91% of payers currently offer reimbursements for telemedicine.
81% offer telepsychiatry.

55% of health care providers listed **forming ACOs** as their **top strategy** for adopting APMs. The second most noted strategy was moving towards **bundled payment models**.



73% of payers noted the lack of providers with appropriate prescribing privileges as a **barrier** to expanding access to pharmacological treatment for substance use disorder

49% increase in consumer online price transparency inquiries for the top 3 commercial payers between 2014 and 2015



58% of health care providers note that their top strategy to address social determinants of health is **partnering with community agencies**



45% of payers list **membership size and infrastructure needs** as the top barriers to increasing the use of APMs

71% of health care providers identified poor reimbursement as the primary barrier to **behavioral health integration**

Top Cost Concerns

Pharmaceutical Drug Spending
Social Determinants of Health
Provider Consolidation
Price Variation

Top Policy Options

Pharmaceutical Transparency
Monitoring Provider Transactions

MEETING THE COST GROWTH BENCHMARK

100% of payers identified pharmaceutical costs as a top area of concern. Most payers report that provider price increases, rather than utilization, are driving medical trend. While most payers had unit cost increases in 2015 in the low single digit range, two payers had decreases in unit costs.

“One key issue is the significant increase in pharmacy costs. As government and private payers are faced with these costs, we need to collectively analyze the impact of new and breakthrough therapies.... In addition to the increased costs associated with prescription drugs generally, we must specifically consider the high costs associated with specialty drugs and personalized medicine.” – BLUE CROSS BLUE SHIELD MA

ALTERNATIVE PAYMENT METHODOLOGY (APM) ADOPTION

Top perceived barriers include membership size, infrastructure needs, lack of alignment within government programs, limitations in current risk adjustment methodologies, and provider reluctance to accept PPO risk.

“As the number of providers not in an APM arrangement becomes smaller and reflects either single providers or providers in a very small office practice, we are approaching a saturation point in terms of viable APM arrangements in the fully-insured market in MA.” – HARVARD PILGRIM HEALTH CARE

ENCOURAGING HIGH-VALUE CONSUMER CHOICES

Only two organizations reported offering cash-back incentives to encourage members to seek care at high-value providers. Payers suggest tiered plans drive patients to high-value providers.

PRICE TRANSPARENCY

The top three payers reported a 49% increase in consumer online price transparency inquiries between 2014 and 2015. Aetna and Harvard Pilgrim both received over 60,000 online price inquiries over the six quarters reported.

PHARMACOLOGIC TREATMENT FOR SUBSTANCE USE DISORDER

Top Strategies to Increase Access

- Removing prior authorization
- Removing cost sharing
- Improving transitions between inpatient and outpatient treatment programs

Top Barriers to Increasing Access

- Few providers with prescribing privileges (although many acknowledge opportunities under CARA)
- Patient and provider bias toward abstinence-only approaches, misunderstanding pharmacologic treatments
- Issues around prior authorization

PHARMACEUTICAL SPENDING GROWTH RATE

Range of Drug Price Change by Category (Per Member Per Year)*			
	COMMERCIAL	MEDICAID	MEDICARE
GENERIC	-4% to +7%	-33% to 13%	-23% to +24%
BRAND	+4% to +21%	+9% to +17%	+2% to +15%
SPECIALTY	+7% to +35%	+2% to +46%	-9% to +41%

*figures rounded

In analyzing price trends by payer, the HPC found:

- For most payers, the rate of growth for specialty drugs is higher than for generic or brand drugs.
- The top three payers (BCBS, HP, Tufts) have increasingly higher rates of growth for generic, brand, and specialty drugs for members in their commercial plans.

PHARMACY BENEFIT MANAGERS (PBMS)

All respondents use a PBM. Four of eleven use CVS/Caremark. All respondents use their PBM for pharmacy contracting and claims processing. Most use their PBM for negotiating prices, discounts, and rebates. Less common responsibilities for PBMs are developing and maintaining the drug formulary or providing clinical/care management programs.

PROVIDERS

Top Cost Concerns

Pharmaceutical Drug Spending
Behavioral Health Reimbursement
Provider Price Variation
Labor Costs

Top Policy Options

Accurate and Timely Care
Management Data

MEETING THE COST GROWTH BENCHMARK

48% of respondents identified pharmaceutical costs as a top area of concern; 31% identified increased reimbursement (primarily for behavioral health services) as a recommended policy change.

"Our top concern is that the Health Care Cost Growth Benchmark is not currently tied to a standardized budget for all provider organizations. A large system with a rich budget, can easily afford to absorb a reduction from 3.6% to 0%. A small organization with an aggressive budget, can't realistically afford a benchmark set at 3.6% or lower." - CENTRAL MASSACHUSETTS INDEPENDENT PHYSICIANS' ORGANIZATION

HIGH-VALUE REFERRALS

Providers lack technology in electronic medical record (EMR) systems that would provide cost or quality data at the point of referral.

ALTERNATIVE PAYMENT MODEL (APM) ADOPTION

Providers are exploring accountable care organizations (ACOs) and patient-centered medical homes (PCMHs) as innovative models. Providers testify that they are working with payers to expand APMs to include: behavioral health, PPOs, infrastructure building, and higher downside risk levels (generally for larger, more experienced providers). Some believe that APM models overemphasize primary care physicians (PCPs), and that specialty care physicians (SCPs) should play a stronger role because they have more influence on medical spending. Top perceived barriers to APM adoption include infrastructure, access to timely and comprehensive data, underfunding/price variation codified in APMs, and behavioral health carve-outs.

RECOGNIZING AND ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Top Strategies

- Social workers and community health workers to coordinate care and perform home visits
- Case management
- Overall population health approaches

Top Barriers

- Data and IT needs
- Lack of incentives to improve behavioral health integration and service access
- Social determinants of health being unaccounted for in risk models
- Language/literacy/cultural barriers
- Inadequate social services and resources

INCREASING ACCESS TO PHARMACOLOGIC TREATMENT FOR SUBSTANCE USE DISORDER

Top Strategies

- Behavioral health and primary care partnerships
- Use of peers, navigators, community health workers
- Community partnerships such as schools and social services
- Addressing high Emergency Department (ED) utilizers

Top Barriers

- 12 of 19 identify reimbursement as the top barrier
- Inability to include behavioral health integration in risk contracts
- Confusion over future APMs
- Complications around physician licensure
- Information sharing, including collaborating with providers from different specialties
- Workforce shortage, especially of psychiatrists
- Credentialing challenges

COST TRENDS HEARING RESOURCES

All resources listed below are available on the [HPC's website](#).

- [Notice of Public Hearing - 2016 Cost Trends Hearing](#)
- [Agenda](#)
- [Witness List](#)
- [Testimony](#)
- [Videos: 2016 Cost Trends Hearing](#)
- [Presentation \(Day One & Two\)](#)
- [CHIA Presentation - Day One](#)
- [HPC Presentation - Day One](#)
- [Dr. Robert Berenson Presentation - Day One](#)
- [AGO Presentation - Day One](#)
- [AGO Presentation - Day Two](#)
- [Lauren Taylor Presentation - Day Two](#)

HPC PUBLICATIONS

All publications listed below are available on the [HPC's website](#).

- **2015 Cost Trends Report Series**
 - [2015 Cost Trends Report](#)
 - [Provider Price Variation](#)
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 - [Provider Price Variation Stakeholder Discussion Series Summary Report](#)
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 - [Research Brief: Serious Illness and End of Life Care in the Commonwealth](#)
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- **2016 Academy Health Annual Research Conference Posters**
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